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ABSTRACT

The authors propose that theoretical confusion and clinical inadequacy regarding child abuse is due, in part, from medical and legal ambiguity concerning child abuse and from dilemmas surrounding social policy and the professional response toward families and children. The dilemmas of social policy (family autonomy versus coercive intervention) and professional response (compassion versus control) are explained and discussed. Problems with the medical and legal responses to child abuse are reviewed. Outlined are several areas for potential conflicts between medical and legal perspectives, including the importance of the abuser's mental state and the seriousness of the injury. The selective ascertainment of marginal families for the attention of child protection professionals is discussed in relation to the social construction of medicine and law. Guidelines are offered to minimize the abuse of power of the professional definers. (Author/SBH)

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The Medicalization and Legalization of Child Abuse

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Summary

Through the cognitive lens of social labeling theory, we see family crisis, and childhood injury, "medicalized" and "legalized," and called "child abuse," to be diagnosed, reported, treated, and adjudicated by doctors and lawyers, their constituent institutions, and the professionals who depend on them for their social legitimacy and support.

Dilemmas of social policy (Family Autonomy versus Coercive Intervention) and professional response (Compassion versus Control) are expressed in conflicts for professionals and in inadequately conceived interventions for families. The selective ascertainment of marginal families for the attention of child protection professionals is discussed in relation to the social construction of medicine and law. Guidelines are offered to minimize the abuse of power of the professional definers.

The Medicalization and Legalization of Child Abuse

Eli H. Newberger, M.D.

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Child abuse has emerged in the last fifteen years as a visible and important social problem. Although a humane approach to "help" both victims of child abuse and their families has developed (and in fact is prominently expressed in the title of one of the more influential books on the subject, "Helping the Battered Child and His Family" [1972])a theoretical framework to integrate the diverse origins and expressions of violence towards children and to inform a rational clinical practice does not exist. Furthermore, so inadequate are the "helping" services in most communities, so low the standard of professional action, and so distressing the consequences of incompetent intervention for the family that we and others have speculated that punishment is being inflicted in the guise of help (Bourne and Newberger, 1977; Juvenile Justice Standards Project, 1977).

What factors encourage theoretical confusion and clinical inadequacy? We propose that these consequences result, in part, from medical and legal ambiguity concerning child abuse and from two fundamental, and in some ways irreconciliable dilemmas about social policy and the response toward families and children. We call these dilemmas Family Autonomy versus Coercive Intervention and Compassion versus Control.

We integrate in this paper a discussion of these dilemmas with a critical sociologic perspective on child abuse management. Through the cognitive lens of social labeling theory, we see family crisis, and childhood injury, "medicalized" and "legalized," and called "child abuse," to be diagnosed, reported, treated, and adjudicated by doctors and lawyers, their constituent institutions, and the professionals who depend on them for their social legitimacy and support.

We are mindful, as practitioners, of the need for effective, rapid, and creative professional responses to child abuse. It is with a view to the development of such responses, which we believe will come through active and vigorous discussion of these issues, that we offer our analysis. We mean not to disparage necessary efforts to help and protect children and their families.

Family Autonomy versus Coercive Intervention: Should Society Intervene in Family Life?

How children's rights -- as opposed to parents' rights -- may be defined and protected is currently the subject of vigorous, and

occasionally rancorous, debate.

The Family Autonomy vs. Coercive Intervention dilemma essentially involves whether society should intervene in situations of risk to children. The traditional autonomy of the family in rearing its offspring was cited by the majority of the U.S. Supreme Court in its ruling against the severely beaten appellants in the distressing "corporal punishment" case (Ingraham v. Wright, et al., [1977]). The schools, serving in loco parentis, are not, in effect, constrained constitutionally from any punishment, however cruel.

Yet in California, a physician seeing buttock bruises of the kind legally inflicted by the teacher in the Miami public schools risks malpractice action if he fails to report his observations (Landeros v. Flood [1976]). He and his hospital are potentially liable for the child's subsequent injury and handicap if they do not initiate protective measures. (Curran, 1977).

The dilemma Family Autonomy vs. Coercive Intervention is highlighted by the recently promulgated draft statute of the American Bar Association's Juvenile Justice Standards Project (1977) which, citing the low prevailing quality of protective services in the U.S., would sharply restrict access to such services. The Commission would, for example, make the reporting of child neglect discretionary rather than mandatory, and would narrowly define the bases for court jurisdiction.

Our interpretation of this standard is that it would make matters worse, not better, for children and their families (Bourne and Newberger, 1977). So long as we are deeply conflicted about the relation of children to the State as well as to the family, and whether children have rights independent of their parents', we shall never be able to articulate with clarity how to enforce them.

Compassion versus Control:

How Should Society Intervene in Family Life?

This dilemma has been postulated and reviewed in a previous paper (Rosenfeld and Newberger, 1977), which discusses the problem implicit in the expansion of the clinical and legal definitions of child abuse to include practically every physical and emotional risk to children. Society cannot, or will not, commit resources nearly commensurate with the exponentially increasing number of case reports which have followed the promulgation of the expanded definitions.

Resources are perceived to be scarce, and we are forced frequently to identify and choose what Goldstein, Freud, and Solnit have called in Beyond the Best Interests of the Child (1973) the "least detrimental alternative" for the child. The family supports which make it safe to keep children in their homes (homemakers, child care, psychiatric and medical services) are in short supply. Mounting attention to the developmental sequelae of child abuse and neglect (Galdston, 1971; Martin, 1976), stimulate an extra urgency to act to protect the identified victims of child abuse and to insure their safe physical growth as well as to promote their adequate psychological development.

Controlling child abuse, Schmitt and Kempe assert in the latest edition of the Nelson Textbook of Pediatrics (1975:111), a standard medical reference, will also prevent murder by the victim, when he grows up:

> "If the child who has been physically abused is returned to his parents without intervention, 5 per cent are killed and 35 percent are seriously reinjured. Moreover, the untreated families tend to produce children who grow up to be juvenile delinquents and murderers, as well as the child batterers of the next generation."

Despite the speculative nature of such conclusions about the developmental sequelae of child abuse (Elmer, 1977), such reports support a policy of separating children from their natural homes in the interest of their and society's protection.

Poor and minority families' children will increasingly be the victims of this social policy of control rather than of compassion, for it is they who preferentially attract the labels "abuse" and "neglect." Affluent families' childhood injuries are more likely to be termed "accidents," where the conceptual model of cause and effect implicit in the name is of an isolated, random event rather than the result of parental fault. (Newberger and Daniel, 1976; Newberger et al, 1977).

(Table One About Here)

Table One presents a graphic display of the two dilemmas of social policy (Family Autonomy versus Coercive Intervention) and social response (Compassion versus Control). The four-fold table illustrates possible action responses. For purposes of this discussion, it is well to think of "compassion" as signifying responses of support, such as provision of adequate income, housing, and child care, and "control" as signifying such punitive responses as "blaming the victim" for his or her reaction to social realities (Ryan, 1971) and as the criminal prosecution of abusing parents.

The Relationship Between Child Abuse and the Professions of Medicine and Law

The importance of a technical discipline's conceptual orientation in defining how it approaches a problem is clearly stated by Mercer (1972:66):

> "Each discipline is organized around a core of basic concepts and assumptions which form the frame of reference from which persons trained in that discipline view the world and set about solving problems in their field. The concepts and assumptions which make up the perspective of each discipline give each its distinctive character and are the intellectual tools used by its practitioners. These tools are incorporated

> in action and problem solving and appear self-evident to persons socialized in the discipline. As a result, little consideration is likely to be given to the social consequence of applying a particular conceptual framework to problem solving.
>
> When the issues to be resolved are clearly in the area of competence of a single discipline, the automatic application of its conceptual tools is likely to go unchallenged. However, when the problems under consideration lie in the interstices between disciplines, the disciplines concerned are likely to define the situation differently and may arrive at differing conclusions which have dissimilar implications for social action."

What we do when children are injured in family crises is shaped by how our professions respond to the interstitial area called "child abuse."

"Medicalization" and its Problems

Though cruelty to children has occurred since documentary records of mankind have been kept (deMause, 1975) it became a salient social problem only after the publication by Kempe and his colleagues describing the "battered child syndrome" (1962). In the four year period after this medical article appeared, the legislatures of all fifty states,stimulated partly by a model law developed under the aegis of the Children's Bureau of the U.S. Department of Health, Education, and Welfare, passed statutes mandating the identification and reporting of suspected victims of abuse.

Once the specific diagnostic category 'battered child syndrome " was applied to integrate a set of medical symptoms, the problem was made medically legitimate. Conrad (1975) has discussed cogently how "hyperactivity" came officially to be known and how it was"medicalized." Medicalization is defined by him as the perception of behavior as a medical problem or illness and the mandating or licensing of the medical profession to provide some type of treatment for it. In effect medicine

becomes an agency of social control for those afflicted .

Pfohl (1977) notes how the publicity surrounding the battered child syndrome report led to a phenomenon of "discovery." His provocative review also takes note of some of the normative and structural elements within the medical profession which appear to have reinforced a reluctance on the part of some physicians to become involved with abuse: the norm of confidentiality between doctor and patient and the goal of professional autonomy. For pediatric radiologists, however, the potential for increased prestige, role expansion, and coalition formation (with psychodynamic psychiatry and pediatrics) may have encouraged identification and intervention in child abuse. Furthermore,

> "..(T)he discovery of abuse as a new 'illness' reduced drastically the intraorganizational constraints on doctors' 'seeing' abuse...Problems associated with perceiving parents as patients whose confidentiality must be protected were reconstructed by typifying them as patients who needed help...The maintenance of professional autonomy was assured by pairing deviance with sickness..." (Pfohl 1977:319)

In some ways, medicine's "discovery" of abuse has benefited individual physicians and the profession. "One of the greatest ambitions of the physician is to discover or describe a 'new' disease or syndrome " (Friedson:252). By such involvement the doctor becomes a moral entrepreneur defining what is normal, proper, or desirable: he becomes charged "with inquisitorial powers to discover certain wrongs to be righted " (Illich, 1976:46). New opportunities for the application of traditional methods are also found as, for example, the recent neurologists' report suggesting the utility of diphenylhydantoin*treatment for child abusing parents (Rosenblatt, Schaeffer, and Rosenthal, 1976).

On the other hand, for many physicians abuse and neglect are

* Dilantin, a commonly-used seizure suppressant

subjects to avoid (Sanders, 1972). First, it is difficult to distinguish, on a theoretical level, corporal punishment that is "acceptable" from that which is "illegitimate." Abuse may be defined variably even by specialists, the definitions ranging from serious physical injury to maltreatment to non-fulfillment of a child's developmental needs (Kempe, 1962; Fontana, 1964; Gil, 1975). Second, it is frequently hard to diagnose abuse clinically. What appears on casual physical examination as bruising, for example, may turn out to be an organic blood dysfunction, or what appear to be cigarette burns may in reality be infected mosquito bites. Since the diagnosis of abuse may require social information about the family -- the acquisition and interpretation of which may be beyond medical expertise -- the doctor may be reluctant to come to a conclusion on his own (Illich, 1976). It may be easier to characterize the clinical complaint by a legitimate medical name, rather than a label which implicitly defines a non-medical -- e.g., parental -- mode of etiology. We see daily situations where the medical taxonomy actively obscures the familial and child developmental causes of the child's syptom: examples are "subdural hematoma" which frequently occurs with severe trauma to babies' heads (the medical name means "collection of blood under the dura mater of the brain") and "enuresis" and/or "encopresis" in child victims of sexual assault (the medical names mean "incontinence of urine or feces.").

Third, abuse is a "dirty problem" arousing strong emotion and moral outrage. To concentrate on the narrow medical issue (the broken bone) instead of the larger familial problem (the etiology of the injury) allows one to avoid confronting the limits of one's technical adequacy and to sidestep confrontation with the abusers(s) toward whom negative feelings inevitably exist. Fourth, physicians are

reluctant to become involved in a time-consuming process which may undercut rapport with the patient by becoming "coercive" (Rosenfeld and Newberger, 1977) and whose outcome might be beyond their control. The potentially alienating nature of the physician-patient interaction, of course, may also have a negative economic impact on the doctor, especially if (s)he is in private practice.

To take the opposite perspective, intervention by the individual practitioner is encouraged because of his/her concern for the child and/or the family (Cupoli and Newberger, 1977) and because of the potential legal liability for not recognizing or dealing with the problem (Curran, 1977).

"Legalization" and its Problems

The legal response to child abuse was triggered by the medicalization of the issue in 1962. Just as the medical profession was reluctant to become involved, so too were there normative elements within law that urged restraint.

First, the American legal system has not traditionally emphasized the rights of children (Fraser. 1977).

Second, there is a strong presumption in favor of family autonomy and the avoidance of "coercive" state intervention (Juvenile Justice Standards Project, 1977). The State usually becomes involved in family life only when parental behavior drops below some acceptable standard and, implicitly, it is usually seen in the best interest of most children to err in favor of non-intervention than to intervene unnecessarily. An issue not yet resolved is whether the State can draw reasonable guidelines or restraints once it begins to intervene. Resources and the administrative ability to monitor family life are limited. But even if resources were limitless, questions of privacy

and individual rights would remain (Hyde, 1975; Whiting, 1976).

On the other hand, once intervention does occur, status and power may accrue to the institutions involved. For example, the growth in the number of Care and Protection cases* before the Boston Juvenile Court "has been phenomenal in recent years...four cases in 1968 and 99 in 1974, involving 175 different children." (Poitrast, 1976) Though these cases have burdened court dockets and personnel, they have also led to acknowledgement of the work of the court. The need for this institution is enhanced because of its recognized expertise in handling special matters.

Though individual lawyers might financially benefit from representing clients in abuse/neglect matters, they - like their physician counterparts - were hesitant to become involved.

> "Public concern over the scope and significance of the problem of the battered child is a comparatively new phenomenon. Participation by counsel in any significant numbers in child abuse cases in Juvenile or family courts is of even more recent origin. It is small wonder that the lawyer approaches participation in these cases with trepidation." (Isaccs :125)

The lawyer, too, might feel handicapped by a need to rely on concepts from social work and psychiatry and data from outside his traditional range of knowledge and expertise. As counsel to the parents, (s)he might be torn between advocacy of their position and that which advances the "best interest" of the child. As counsel to the petitioner, (s)he might have to present a case with little tangible evidence because abuse/neglect is frequently unclear and difficult to prove.

*Care and protection cases are those juvenile or family court actions which potentially transfer, on a temporary or permanent basis, legal and/or physical custody of a child from his biological parents to the state.

Lawyers are also conflicted over how intervention should occur (whether courts or legislatures should play the major role), the amount of formality desirable in the legal proceedings and the propriety of negotiation as opposed to confrontation.

Potential Conflicts Between Medical and Legal Perspectives

Despite the common reasons for the "medicalization" and the "legalization" of child abuse, which have to do with the structures, goals, and ethics of the professions, there are several areas where the two orientations conflict:

(1) the importance of the abuser's mental state. To lawyers whether the abuser intentionally or accidentally inflicted injury on a child is an important variable. So-called "accidents" are less likely to trigger intervention. To the medical clinician, however, mental state may be less relevant: first, it requires a diagnostic formulation frequently difficult or impossible to make on the basis of available data; second, the family dynamics which produce "accidents" in some children (e.g., inattention or carelessness) often resemble those which lead to inflicted injury in others; and third, the difference between what is defined as an "accident" and what is labeled "trauma" may depend on the ethnic status and/or social class of those allegedly responsible for the harm; (Newberger et al, 1977).

(2) the seriousness of the injury. To lawyers intervention might be warranted only when abuse/neglect results in serious harm to a child. (Juvenile Justice Standards Project, 1977) To the clinician, however, any inflicted injury or neglect might justify a protective response.

"The trick is to prevent the abusive case from becoming the terminal case." (Fraser, 1974: 2) Early intervention may prevent the abuse from being repeated or from becoming more serious;

(3) the definition of the abuser. To lawyers the abuser might be defined as a wrongdoer who has injured a child-victim. To clinicians both the abuser and child might be perceived as victims influenced by sociological and psychological factors beyond their control. (Gelles, 1973; Newberger, 1973)

(4) the role of law. To lawyers the law and legal institutions become involved in child abuse when certain facts fit a standard of review. To clinicians, the law may be seen as an instrument to achieve a particular therapeutic or dispositional objective (e.g., the triggering of services or of social welfare involvement) even if, as is most often the case, the data to legally support such objective are missing or ambiguous. The clinician's approach to the abuse issue is frequently subjective or intuitive (e.g., a feeling that a family is under stress or needs help, or that a child is "at risk") while the lawyer demands evidence. Attorneys are proudly unwilling to accept conclusions or impressions lacking empirical corroboration.

Despite these potential or actual differences in orientation, both medicine and law have developed a treatment or therapeutic approach to abuse/neglect instead of a punitive one. This approach might be surprising in view of the stigma of child battering and the intense negative reactions engendered toward abusers. Treatment may itself be punitive or be perceived as punitive. As Illich writes: "The medical label may protect the patient from punishment only to submit him to interminable instruction, treatment, and discrimination, which are inflicted on him for his professionally presumed benefit" (Illich,

1976: 90; see also Kittrie, 1971).

Doctoring and Lawyering the Disease

To physicians, defining abuse as a disease or medical syndrome makes natural the treating (helping) alternative, since both injured child and abuser are viewed as "sick" - the one, physically, the other psychologically or socially. Physicians may also be psychologically reluctant to treat abuse of a child by "abusing" the parent through punishment.

For lawyers, however, the treatment/sickness perspective may be explained by the following factors:

(1) The fact that child abuse was "discovered" by physicians influenced the model adopted by other professionals. As Friedson notes: "Medical definitions of deviance have come to be adopted even where there is no reliable evidence that biophysical variables 'cause' the deviance or that medical treatment is any more efficacious than any other kind of management " (Friedson:328).

Chambliss (1964) argues that when changed social conditions create a perceived need for legal changes, "these alterations will be effected through the revision and refocusing of existing statutes." (cf., the mandatory reporting laws). Weber, in addition, contends that "status" groups (e.g., physicians) generally determine the content of law (Rheinstein, 1954).

(2) the rehabilitative ideal has been in ascendance in criminal law especially in the juvenile and family courts which handle most abuse cases (Allen, 1964).

(3) the criminal or punitive model will not protect the child and has serious defects when applied to this issue. Abusers, for example, may hesitate to seek help if they are fearful of prosecution; abuse is

often difficult to prove beyond a reasonable doubt; constitutional issues such as the privilege against self-incrimination are not easily resolved; if an alleged abuser is threatened with punishment and then found not guilty, (s)he may feel vindicated, reinforcing the pattern of abuse; therapy is made more difficult by prosecution even if found guilty, the abuser is usually given only slight punishment, for example, a short jail term or probation; if the abuser is incarcerated, the non-abusing parent and the other family members equally suffer (the relationship between spouse is undercut, childrearing falls on one parent, etc.); if incarcerated, the abuser when released may be even more aggressive and vindictive toward the objects of abuse.

The Implementation of Treatment

Physicians, in defining abuse as a medical problem and in providing treatment, become what sociologists call agents of social control (Becker, 1963). Though the technical enterprise of the physician claims value-free power (Illich, 1976) in fact certain individuals are more likely to be defined as abusers than are others.* This diagnostic discrepancy is facilitated by certain factors - situational, within the definer, and within those labeled:

(1) the fact that abuse is not theoretically or clinically clear (see above) increases the likelihood of subjective evaluation.

(2) characteristics identified with the "battered child syndrome" (social isolation, premature birth of child, large family, frustration, unemployment, physical punishment as a legitimate childrearing technique) are frequent concomitants of poverty, i.e.,the poor are more likely to be perceived as abusive toward their children;

*Intervention is generally encouraged by the treatment orientation (i.e., the family will only be helped rather than harmed) and by what Scheff calls the medical decision rule: it is better to wrongly diagnose illness and "miss" health than it is to wrongly diagnose health and "miss" illness (Scheff, 1972).

(3) Hospital-connected physicians are more likely to be aware of, and act upon their recognition of, child abuse than are those in private practice. Poor people are more likely to frequent hospital emergency wards and clinics than are the affluent, i.e., the poor are more likely to reveal abuse (greater social visibility) and, therefore, have such officially perceived;*

(4) In labeling theory it is axiomatic that the greater the social distance between the typer and the person singled out for typing, the broader the type and the more quickly it may be applied (Rubington and Weinberg, 1973). A pre-existent social distance exists between physicians and those presenting at clinics and emergency rooms. In the doctor-patient relationship, the physician is always in a superordinate position because of her/his expertise, i.e. social distance is inherent. This distance increases once the label of abuser has been applied. Importantly, the label is less likely to be applied if physician (diagnostician) and possible abuser share similar characteristics, especially socioeconomic status. The more serious the abuse or the easier it is to identify, however, the less likely is social class to influence the labeling process.

(5) Once the label "abuser" has attached, it is very difficult to remove, so even innocent behavior of a custodian may be viewed with suspicion. The tenacity of a label, of course, increases as does the official processing. At Children's Hospital, until quite recently, a red star was stamped on the permanent medical record of any child who might have been abused, a process which encouraged professionals to suspect abuse/neglect (and to act on that assumption) at any future time the child would present with a medical problem. The professional thus engages in an intricate process of selection, finding facts which fit

*Because of sampling bias physicians cannot tell whether the abusers they see are representative of abusers or, indeed, whether what they define as abuse is normative or differs from the childrearing practices of the population from which the sample derives (Newberger and Daniel, 1976).

the label which has been applied, responding to a few deviant details set within a vast array of entirely acceptable conduct. (Schur calls this "retrospective reinterpretation" [Schur, 1971].) This also is a consequence of the pathological model wherein "persons are likely to be studied in terms of what is 'wrong' with them," there being a "decided emphasis on identifying the characteristics of abnormality" (See Mercer, 1972).

(6) The response of the patient to the agent of social control affects the perceptions and behavior of the controller. For example, if abuse has occurred and the alleged abuser is repentant, i.e., a consensus exists between abuser and labeller that a norm has been violated, the label of "abuser" will be less firmly applied than if the abuser accepts his/her behavior as proper.*

(7) If the medical evidence would sustain a diagnosis of abuse, but social data are inconsistent with such evaluation (e.g., the family is appropriately concerned about the child; the explanation of how the injury occurred is plausible, etc.) the label of "abuser" is less likely to be applied than if either social data are absent (secrecy or withdrawal as indicative of guilt and fear) or congruent with medical opinion. Abuse, that is, may go undetected if an abuser acts in such a way as to achieve a social label of conformity.

If the diagnosing physician is biased, this fact affects the legal procedures set up to determine whether or not his labelling is legitimate. Reports filed with a Department of Public Welfare, for example, fall heavily on the poor,while Paulsen has emphasized that the juvenile or family court is a "poor man's court" and that poor children fall into the neglect category more frequently than the offspring of the well-to-do:

*See Gusfield (1967) for the different reactions to repentant, sick and enemy deviants. Also note the study by Piliavin and Briar showing that juveniles apprehended by the police receive more lenient treatment if they appear contrite and remorseful about their violations than if they do not (1964).

> "What one regards as proper care may, indeed, be a matter of dispute reflecting class and cultural differences. Standards of child rearing adequate in one cultural setting may seem appalling in another. Neglect defined as raising a child in an environment which is 'injurious or dangerous' may create a hazard for parents without means." (Paulsen:699)

The Consequences of Treatment for the Abuser

Once abuse is defined as a sickness, it becomes a condition beyond the actor's control or "unmotivated." (Parsons, 1951) Though treatment, not punishment, is warranted, the type of treatment depends on whether or not the abuser is "curable," "improvable" or "incurable" and on the speed with which such a state can be achieved (Freidson, 1970).

To help the abuser is seen as a less important goal than is the need to protect the child. If the abuser's behavior cannot quickly be altered, and the child remains "at risk," the type of intervention will differ accordingly (e.g., the child is more likely to be placed in foster care). The less "curable" is the abuser, the less treatment offered and the more punitive does society's response appear. Even removal of a child, however, defined as punitive by the parents, may be seen as helpful to the parents by those removing ("It will give you a chance to resolve your own problems," etc.)

Whatever the type of treatment, there are certain consequences for those labelled "abusers:"

(1) conflicting emotions. Abusers may be afraid of "getting caught" because of punishment and social stigma. They may express hostility because of implicit or explicit criticism made of them and their childrearing practices yet feel relief because they love their children and want help in stopping their destructive behavior. The fact that they see themselves as "sick" increases their willingness to seek help,*the response of the professionals strongly influencing which emotion predominates.

*This attitude is probably due to the lesser social stigma attached to the "sick," as opposed to the "criminal," label.

(2) reinforced self-definition. Despite professional sensitivity, however, abusers usually have a negative self-image which is only reinforced by official scrutiny. Professionals themselves approach abusers ambivalently - wanting to help, yet blaming the victim - for, as Freidson writes: "While the label of illness does seem to function to discourage punitive reactions, it does not discourage condemnatory reactions" (Freidson:253).

The abusers are likely to accept whatever definition the more powerful labellers apply.* This definition, of course, has already been accepted by much of the larger community because of the definers' power. As Davis writes:

> "The chance that a group will get community support for its definition of unacceptable deviance depends on its relative power position. The greater the group's size, resources, efficiency, unity, articulateness, prestige, coordination with other groups, and access to the mass media and to decision-makers, the more likely it is to get its preferred norms legitimated(Davis,1975)

Acceptance of definition by the abusers, however, is not based alone on the power of the labellers. Though some would consider the process "political castration" (Pitts, 1968) in fact as long as he is defined as "ill" and takes on the sick role (Scheff, 1966) the abuser is achieving the label and role desired. Though afflicted with a stigmatized illness (and thus "gaining few if any privileges and taking on some especially handicapping new obligations" [Freidson:236-238]) he at least is sick rather than sinful or criminal. If the abuser receives conflicting messages from the same control agent (e.g., "you are sick and criminal") or from different control agents in the treat-

*Effective social typing flows down rather than up the social structure. For example, when both parents induct one of their children into the family scapegoat role, this is an effective social typing because the child is unable not to take their definition of him into account even if he so wishes. (See Rubington and Weinberg, 1973) Sometimes it is difficult to know whether the abuser has actually accepted the definition or is merely "roleplaying" in order to please the definer.

ment network (e.g., from doctors who use the sick label, while lawyers use the criminal), confusion and upset predictably result (Stoll, 1968).

As an example of how social definitions are accepted by the group being defined, it is interesting to examine the basic tenets of Parents Anonymous, which began as a self-help group for abusive mothers. To illustrate:

> "A destructive, disturbed mother can, and often does, produce through her actions a physically or emotionally abused, or battered child. Present available help is limited and/or expensive, usually with a long waiting list before the person requesting help can actually receive treatment... We must understand that a problem as involved as this cannot be cured immediately...the problem is within us as a parent.." (Kempe and Helfer 1972:50-51, emphasis added)

To Parents Anonymous child abuse appears to be a medical problem, and abusers are sick persons who must be treated.

The Consequences of Treatment for the Social System

Obviously the individual and the social system are interrelated so that each mutually influences the other. For example, the fact that abusers are defined as sick means that there is a low rate of criminal prosecutions for abuse and that reports of suspected abuse are usually sent to welfare, as opposed to police, departments.

Since abusers are frequently treated in hospitals, along with the abused, hospital staff become brokers for adult services and definers of childrens' rights. Once abuse is defined, that is, poor people might get supports (day care, parent-child training, homemaker services, etc.) otherwise unavailable; children might get care and protection impossible without institutional intervention.

If, as is customary, however, resources are in short supply, the desire to treat a case in a particular way may not be feasible. Under this condition different treatment strategms, or even clearly punitive alternatives may be implemented. That is, if day care and parent-child

counseling are nonexistent, court action and foster placement might become the only option. As Stoll observes, "(T)he best therapeutic intentions may be led astray when opportunities to implement theoretical guidelines are not available." (1968:51)

Treating abuse as a sickness has, ironically, made it more difficult to "cure." First, there are not enough therapists to handle all of the diagnosed cases, nor do the abusers have the time or money or disposition for long-term therapeutic involvement. Abusers may not be able to develop sufficient trust and rapport with a therapist as they have rarely been close to another adult. Many, moreover, lack the introspective and conceptual abilities required for successful psychological therapy (Spinetta and Rigler, 1973).

Second, those who mistreat their children, but are not labelled sick (e.g., the middle-class parent who gives a youngster Ritalin to control childishness, otherwise known as "hyperactivity" [Schrag, 1975]) are able to rationalize their behavior.

Third, and most important, abuse as a problem is individualized. As Parent's Anonymous emphasizes, abuse is the abuser's problem, that is, its causes and solutions reside in individuals rather than in the social system (Gelles, 1973; Conrad, 1975). Instead of addressing the issues of poverty and inequality, or the general lack of social and medical resources in American society (Newberger, Newberger, and Richmond, 1976) the abuser (like the black who fails and blames self rather than racism) is blamed and underlying structural factors ignored.

Indeed the strong emphasis on child abuse as an individual problem means that other equally severe problems of childhood are ignored or de-emphasized (Gil, 1970). Child abuse itself may also increase as parents and professionals are obliged to "package" their problems and diagnoses in a competitive market where services are in short supply.

As Tannenbaum observed in 1938 (in Crime and the Community):

> "Societal reactions to deviance can be characterized as a kind of 'dramatization of evil' such that a person's deviance is made a public issue. The stronger the reaction to the evil, the more it seems to grow. The reaction itself to generate the very thing it sought to eliminate." Seems

Conclusion: Dispelling the Myth of Child Abuse

As clinicians, we are convinced that with intelligence, humanity, and the application of appropriate interventions, we can help families in crisis.

We believe, however, that short of coming to terms with -- and changing -- certain social, political, and economic aspects of our society, we will never be able to adequately understand and address the origins of child abuse and neglect. Nor will the issues of labeling be adequately resolved unless we deal straightforwardly with the potentially abusive power of the helping professions. If we can bring ourselves to ask such questions as "Can we legislate child abuse out of existence?" and "Who benefits from child abuse?" then perhaps we can more rationally choose among the action alternatives displayed in the conceptual model (Table One).

Although we would prefer to avoid coersion and punishment, and to keep families autonomous and services voluntary, we must acknowledge the realities of family life and posit some state role to assure the wellbeing of children. In making explicit the assumptions and values underpinning our professional actions, perhaps we can promote a more informed and humane practice.

Because it is likely that clinical interventions will continue to be class and culture-biased, we propose the following five guidelines to minimize the abuse of power of the definer.

1. Give physicians, social workers, lawyers and other intervention agents social science perspectives and skills.

Critical intellectual tools should help clinicians to understand the implications of their work, and, especially, the functional meaning of the labels they apply in their practices.

Physicians need to be more aware of the complexity of human life, especially its social and psychological dimensions. The "medical model" is not of itself inappropriate; rather, the conceptual bases of medical practice need to be broadened, and the intellectual and scientific repertory of the practitioner expanded (Engel, 1977). Diagnostic formulation is an active process and it carries implicitly an anticipation of intervention and outcome. The simple elegance of concepts like "child abuse" and "child neglect" militate for simple and radical treatments.

Lawyers might be helped to learn that in child custody cases they are not merely advocates of a particular position. Only the child should "win" a custody case, where for example, allegations of "abuse" or "neglect," skillfully marshalled, may support the position of the more effectively represented parent, guardian, or social worker.

2. Acknowledge and change the prestige hierarchy of helping professions.

The workers who seem best to be able to conceptualize the familial and social context of problems of violence are social workers and nurses. They are least paid, most overworked, and have as a rule minimal access to the decision prerogatives of medicine and law. We would add that social work and nursing are professions largely of and by women, and we believe we must objectively come to terms with the many realities -- including sexual dominance and subservience -- which

make these professions unable to carry forth with appropriate respect and support. (We have made a modest effort in this direction at our own institution, where our interdisciplinary child abuse consultation program is organized under the aegis of the administration rather than of a medical clinical department. This is to foster to the extent possible colleagial status and communication on a coequal footing among the disciplines represented in the Trauma X Group [social work, nursing, law, medicine, and psychology].)

3. Build theory.

We need urgently a commonly understandable dictionary of concepts which will guide and inform a rational practice. A more adequate theory base would include a more etiologic (or causal) classification scheme for children's injuries which would acknowledge and integrate diverse origins and expressions of social, familial, child developmental, and environmental phenomena. It would conceptualize strength in families and children as well as pathology. It would orient intervenors to the promotion of health rather than to the treatment of pathology.

A unified theory would permit coming to terms with the universe of need. At present, socially marginal and poor children are virtually the only ones susceptible to being diagnosed as victims of abuse and neglect. More affluent families' offspring, whose injuries are called "accidents" and who are often unprotected, are not included in "risk" populations. We have seen examples of court defense where it was argued (successfully) that because the family was not poor, they did not fit the classic archetypes of abuse or neglect.

The needs and rights of all children need legally to be spelled out in relation to the responsibilities of parents and of the state. This is easier said than done. It shall require not only a formidable

effort at communication across disciplinary lines but a serious coming to terms with social and political values and realities.

4. Change social inequality.

We share Gil's view (1970) that inequality is the basic problem underlying the labeling of "abusive families" and its consequences. Just as children without defined rights are ipso facto vulnerable, so too, does unequal access to the resources and goods of society shape a class hierarchy which leads to the individualization of social problems. Broadly-focused efforts for social change should accompany a critical review of the ethical foundations of professional practice. As part of his or her formation as doctor, lawyer, social worker, or police officer, there could be developed for the professional a notion of public service and responsibility. This would enable individuals to see themselves as participants in a social process and to perceive the problems which they address in their work at the social as well as the individual level of action.

5. Assure adequate representation of class and ethnic groups in decision-making forums

Since judgements about family competency can be affected by class and ethnic biases, they should be made in settings where prejudices can be checked and controlled. Culture-bound value judgements in child protection work are not infrequent, and a sufficient participation in case management conferences of professionals of equal rank and status and diverse ethnicity can assure both a more appropriate context for decision making and better decisions for children and their families.

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DILEMMAS OF SOCIAL POLICY AND PROFESSIONAL RESPONSE

RESPONSE	FAMILY AUTONOMY	*Versus*	COERCIVE INTERVENTION
Compassion ("support")	1 Voluntary child development services 2 Guaranteed family supports: e.g. income, housing, health services		1 Case reporting of family crisis and mandated family intervention 2 Court-ordered delivery of services
Versus			
Control ("punishment")	1 "Laissez-faire": No assured services or supports 2 Retributive response to family crisis		1 Court action to separate child from family 2 Criminal prosecution of parents

Table One: Dilemmas of Social Policy and Professional Response